

# MEDICAL RECORD SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of the Surgeon General

**REPORT TITLE:**  
**SLEEP HISTORY QUESTIONNAIRE**

**OTSG APPROVED (Date)**  
1 Apr 10

Age \_\_\_\_\_ DOB \_\_\_\_\_ Male/Female (circle) Height \_\_\_\_\_ Weight \_\_\_\_\_

Home Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Home: \_\_\_\_\_

Work: \_\_\_\_\_

Cell: \_\_\_\_\_

Circle One: Active Duty

Retired

Civilian

Rank: \_\_\_\_\_

MOS \_\_\_\_\_

Unit Phone # \_\_\_\_\_

Are you deploying in the next 12 months? Yes No

If yes, what month/yr \_\_\_\_\_

Are you retiring in the next 12 months? Yes No

If yes, what month/yr \_\_\_\_\_

Are you undergoing an MEB? Yes No

Are you PCSing? Yes No

If yes, what month/yr \_\_\_\_\_

Are you ETSing? Yes No

If yes, what month/yr \_\_\_\_\_

Are you going on leave? Yes No

If yes, what month/yr \_\_\_\_\_

Are you going on TDY? Yes No

If yes, what month/yr \_\_\_\_\_

What problems are you having with your sleep?  
\_\_\_\_\_  
\_\_\_\_\_

Have you had a sleeping problem diagnosed in the past? Yes No If yes, describe:  
\_\_\_\_\_  
\_\_\_\_\_

**EXCESSIVE SLEEPINESS:**

Do you feel excessively sleepy in the daytime? Yes No If yes, how long? \_\_\_\_\_ months/years

**Epworth Sleepiness Scale**

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

**0= Would never doze**

**1= Slight chance of dozing**

**2= Moderate chance of dozing**

**3= High chance of dozing**

|   |  |
|---|--|
| Sitting and reading   |  |
| Watching TV   |  |
| Sitting, inactive in a public place                           |  |
| Riding as a passenger in the car for an hour without a break  |  |
| Lying down to rest in the afternoon when circumstances permit |  |
| Sitting and talking to someone                                |  |
| Sitting quietly after a lunch without alcohol                 |  |
| In a car, while stopped for a few minutes in traffic          |  |
| Total   |  |

*(Continue on reverse)*

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE (YYYYMMDD)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name, -last, first, middle; grade; date; hospital or medical facility)

HISTORY/PHYSICAL

FLOW CHART

OTHER EXAMINATION OR EVALUATION

OTHER (Specify)

DIAGNOSTIC STUDIES

TREATMENT

**RESPIRATION:**

| <b>How often do you have or do the following:</b> | <b>Never</b> | <b>Sometimes</b> | <b>Routinely</b> |
|---|--------------|------------------|------------------|
| Snoring   |              |                  |                  |
| Stop breathing when sleeping                      |              |                  |                  |
| Morning Headaches                                 |              |                  |                  |
| Awaken gasping/choking                            |              |                  |                  |
| Dry Mouth   |              |                  |                  |

**SLEEP SCHEDULE:**

|  | <b>Weeknights</b> | <b>Weekends</b> |
|--|-------------------|-----------------|
| What time do you go to bed?                    |                   |                 |
| What time do you get up in the mornings?       |                   |                 |
| How many hours of sleep do you get each night? |                   |                 |
| How many hours do you nap per day?             |                   |                 |

**SLEEP HYGIENE:**

- Do you usually feel well rested upon awakening?      Yes   No
- Do you watch TV in bed?      Yes   No
- Do you look at your bedroom clock at night?      Yes   No
- Do you have arguments in bed?      Yes   No
- Do you worry in bed?      Yes   No
- Does sleep position affect your snoring?      Yes   No
- If yes, in what position do you sleep best? \_\_\_\_\_
- Do you currently do shift work?      Yes   No
- Have you done shift work in the past?      Yes   No
- If yes, do you have trouble sleeping while performing shift work?      Yes   No
- Does your spouse perform shift work?      Yes   No

**WEIGHT HISTORY:**

- Your weight at age 20 \_\_\_\_\_ lbs.
- Your weight at age 30 \_\_\_\_\_ lbs.
- Your weight at age 40 \_\_\_\_\_ lbs.
- Your weight at age 50 \_\_\_\_\_ lbs.
- Your weight at age 60 \_\_\_\_\_ lbs.
- Your heaviest weight \_\_\_\_\_ lbs. at age \_\_\_\_\_

**INSOMNIA:**

Answer the following questions assuming "night" means your major sleeping time.

- Do you often have trouble getting to sleep at night?      Yes   No
- What is the average number of minutes it takes you to fall asleep at night?      \_\_\_\_\_ Minutes
- Do you have long periods when you awaken and are not able to get back to sleep?      Yes   No
- If yes, how long are these periods of wakefulness when added together?      \_\_\_\_\_ Minutes
- What is the average number of times per night you wake up?      \_\_\_\_\_ Times
- If yes, why do you awaken? (Circle):
- Pain                  Bathroom                  Noise                  Light
- Nightmares          Difficulty Breathing          Night Terrors          Choking/Gasping
- Are you bothered by waking up too early and not being able to go back to sleep?      Yes   No

**MOVEMENT:**

- Do you ever have restless legs (a strong desire to move your legs while at rest, relieved with moving your legs, and the sensation returns when you rest your legs)?      Yes   No
- If yes, is this something that you think routinely interferes with your sleep?      Yes   No
- Do these symptoms occur more in the evening than any other times?      Yes   No
- Do you awaken yourself by kicking your legs, or other sudden movements, during the night?      Yes   No
- Has your partner ever complained of your legs kicking, or other movements, while asleep?      Yes   No

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REPORT TITLE:  
**Sleep Study Questionnaire (Continued)**

OTSG APPROVED (Date)  
 1 Apr 10

**PARASOMNIAS/ OTHER:**

|   |        |
|---|--------|
| Did you have a sleep problem as a child?<br>If yes, describe _____  | Yes No |
| Do you currently have nightmares or night terrors?  | Yes No |
| Do you grind or clench your teeth at night?   | Yes No |
| Did you frequently wet the bed as a child?  | Yes No |
| Have you ever wet the bed as an adult?  | Yes No |
| Have you ever been told that you walk in your sleep?  | Yes No |
| Have you recently walked in your sleep?   | Yes No |
| Have you ever been told you make unusual movements such as talking,<br>swinging arms about, acting out dreams, etc. during sleep? | Yes No |
| Have you ever felt sudden muscle weakness when you laughed or got angry?  | Yes No |
| Have you ever been unable to move your body just as you were falling asleep or waking up?   | Yes No |
| Have you ever had exceptionally vivid dreams just as you were falling asleep or waking up?  | Yes No |
| Have you ever had a sleep related driving accident or a near miss?  | Yes No |

**MEDICAL AND SURGICAL HISTORY:**

| Mark any of the following disorders that you have been diagnosed with (active problem or cured) | Yes | No |
|---|-----|----|
| Insomnia  |     |    |
| Narcolepsy  |     |    |
| Restless Legs Syndrome  |     |    |
| COPD  |     |    |
| Asthma  |     |    |
| Coronary Artery Disease   |     |    |
| Congestive Heart Failure  |     |    |
| Atrial Fibrillation   |     |    |
| Diabetes Mellitus   |     |    |
| Hypertension  |     |    |
| High Cholesterol  |     |    |
| Reflux Disease (GERD)   |     |    |
| Renal Failure   |     |    |
| Stroke  |     |    |
| Depression  |     |    |
| Anxiety   |     |    |
| Post Traumatic Stress Disorder (PTSD)   |     |    |

**FAMILY HISTORY:**

| Mark any of the following disorders that an immediate family member has been diagnosed with (active problem or cured) | Yes | No |
|---|-----|----|
| Obstructive Sleep Apnea   |     |    |
| Narcolepsy  |     |    |
| Restless Leg Syndrome   |     |    |
| Coronary Artery Disease   |     |    |
| Hypertension  |     |    |

*(Continue on reverse)*

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE (YYYYMMDD)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name, -last, first, middle; grade; date; hospital or medical facility)

- |  |  |
|--|--|
| <input type="checkbox"/> HISTORY/PHYSICAL                | <input type="checkbox"/> FLOW CHART      |
| <input type="checkbox"/> OTHER EXAMINATION OR EVALUATION | <input type="checkbox"/> OTHER (Specify) |
| <input type="checkbox"/> DIAGNOSTIC STUDIES              |  |
| <input type="checkbox"/> TREATMENT                       |  |

